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No. 03-888

In the Supreme Court of the United States

PETER MACKBY, PETITIONER

v.

UNITED STATES OF AMERICA

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether the evidence in this case established that the claims for payment that petitioner caused to be submitted were "false" within the meaning of the False Claims Act (FCA), 31 U.S.C. 3729 *et seq.*

2. Whether the district court's calculation of damages in this case was consistent with the terms of the FCA.

3. Whether the government is required to prove damages in order to establish liability and recover civil penalties under the FCA.

4. Whether the court of appeals correctly held that the civil penalties awarded in this case did not violate the Excessive Fines Clause of the Eighth Amendment.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1-15) is reported at 339 F.3d 1013.[1] A prior opinion of the court of appeals (Pet. App. 16-33) is reported at 261 F.3d 821.[2] The opinion of the district court (Pet. App. 37-55) is reported at 221 F. Supp. 2d 1106. A prior opinion of the district court (Pet. App. 56-71) is unreported.

[1] The court of appeals initially issued a memorandum opinion, Pet. App. 34-36, but the court withdrew that opinion and replaced it with the opinion referred to in the text. See *id.* at 2.

[2] An earlier opinion of the court of appeals, reported at 243 F.3d 1159, was withdrawn. It is not included in the appendix to the petition for a writ of certiorari.

JURISDICTION

The judgment of the court of appeals was entered on August 12, 2003. A petition for rehearing was denied on September 12, 2003 (Pet. App. 73). The petition for a writ of certiorari was filed on November 13, 2003. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. At all times relevant to this case, the Medicare Program was administered by the Health Care Financing Administration (HCFA), a component agency of the Department of Health and Human Services. See 42 U.S.C. 1395u.[3] Medicare Part A generally provides hospital insurance benefits to the elderly and disabled. See 42 U.S.C. 1395c to 1395i-2. Medicare Part B is a federally subsidized, voluntary insurance program that pays a portion (typically 80%) of the cost of certain medical and other health services, including physician and laboratory services, not covered by the Part A program. See 42 U.S.C. 1395j to 1395x(s). Part B claims were paid by HCFA from the Medicare Trust Fund through private insurance carriers with which HCFA contracted. See 42 U.S.C. 1395u. The carrier involved in this matter was Blue Shield of California. Pet. App. 66.

Physical therapy services were reimbursed through Medicare Part B only under two circumstances: (1) when provided by a physical therapist in independent practice (PTIP); and (2) when provided by a physician or by appropriately licensed and qualified

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[3] After the events at issue in this case, HCFA became known as the Centers for Medicare and Medicaid Services. See 66 Fed. Reg. 35,437 (2001).

professional employees whose services were "incident to" a physician's care. Pet. App. 66. In order to receive reimbursement, a PTIP or physician was required to have in effect an agreement to participate in Medicare. *Ibid.*

The governing law placed limits on the amount that a PTIP could bill on behalf of any one Medicare beneficiary (patient) in any calendar year. In 1992 and 1993, the limit was $750 per year; from 1994 through 1996, it was $900 per year. During the relevant time period, no such limit was imposed on physical therapy services provided by or under the supervision of physicians. Pet. App. 67.

At the time, bills to Medicare Part B were submitted on a HCFA 1500 claim form, the general form used for outpatient services. See Pet. App. 82 (sample of relevant form). Box 24K of the form was used to identify the provider identification number (PIN) for the individual providing the services, a carrier-assigned 9-digit number for the performing physician or PTIP. *Id.* at 58. Box 33 was used to identify the name, address, telephone number, and carrier-issued PIN of the physician or PTIP who was seeking payment. *Ibid.*

2. The False Claims Act (FCA), 31 U.S.C. 3729 *et seq.*, prohibits any person from "knowingly present[ing], or caus[ing] to be presented, to an officer or employee of the United States Government or a member of the Armed Forces of the United States a false or fraudulent claim for payment or approval." 31 U.S.C. 3729(a)(1). The FCA also prohibits a variety of related deceptive practices involving government funds and property. 31 U.S.C. 3729(a)(2)-(7). A person who violates the FCA is liable to the United States for civil penalties and for three times the amount of the government's damages. 31 U.S.C. 3729(a). At the time of

the events at issue in this case, the Act provided for civil penalties of "not less than $5,000 and not more than $10,000" for each false claim. 31 U.S.C. 3729(a).[4]

3. In 1982, Michael Leary, a licensed physical therapist, and petitioner Peter Mackby entered into a partnership to own and operate Asher Clinic in Larkspur, California. Pet. App. 57. During the partnership, Asher Clinic billed Medicare using Leary's PIN, and the Medicare checks were made out to Leary and sent to him at the Clinic. *Ibid.* In June 1988, Leary and petitioner dissolved their partnership pursuant to a court settlement. *Ibid.* Petitioner purchased Leary's interest in the Clinic on June 20, 1988. *Ibid.* Once Leary terminated his relationship with Asher Clinic, the Clinic was not eligible for reimbursement under Medicare Part B, since petitioner did not qualify as a PTIP. See *id.* at 8-9.

On June 22, 1988, petitioner instructed Medicom, the billing service for the Clinic, to substitute the PIN of his father, Dr. M. Judson Mackby, for Leary's PIN on Asher Clinic's Medicare claims. Petitioner also told Maridy Barnett, Asher Clinic's office manager, to use Dr. Mackby's medical license number in billing Medicare and other third parties. Petitioner gave Barnett his father's PIN to substitute for Leary's. Accordingly, Asher Clinic's HCFA 1500 claim forms began to include Dr. Mackby's PIN in Boxes 24K and 33. Use of Dr. Mackby's PIN in that manner indicated either that Dr. Mackby had performed the physical therapy services or

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[4] The civil penalty range under the FCA was recently adjusted upward to a minimum penalty of $5500 and a maximum penalty of $11,000, pursuant to a statutory mandate applicable to civil penalties enforced by all federal agencies. See 64 Fed. Reg. 47,104 (1999).

that the therapy had been performed incident to his care. Pet. App. 58-59.

Thereafter, the Medicare reimbursement checks were made payable to "M. Judson Mackby, M.D.," and were sent to Asher Clinic's address. Asher Clinic used a rubber endorsement stamp with Dr. Mackby's name to endorse and deposit the checks. The Explanation of Medicare Benefits (EOMBs), which Blue Shield sent to Asher Clinic and to Medicare beneficiaries, identified Dr. Mackby as the provider of services at the Clinic. The EOMBs that were sent to Asher Clinic were addressed to "M. Judson Mackby." All Medicare audit inquiries and Medicare Bulletins were addressed to Dr. Mackby at the Clinic's address. Trial testimony showed that the administrators of the Medicare program believed that the inclusion of Dr. Mackby's PIN in Boxes 24K and 33 on the HCFA 1500 meant either that Dr. Mackby was performing the billed services or that the billed services were performed incident to his care. Pet. App. 59.

In fact, Dr. Mackby played no role in the Clinic's provision of services. From 1986 until 1994, Dr. Mackby lived in Connecticut; he moved to Kentucky in 1994. Dr. Mackby never provided medical services or physical therapy at Asher Clinic, never referred patients to Asher Clinic, was never involved in the treatment or care of patients at Asher Clinic, and was unaware that his name and PIN were being used by his son and Asher Clinic to obtain Medicare reimbursement. Pet. App. 60.[5]

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[5] Petitioner could have sought certification of the Clinic as a rehabilitation agency to receive reimbursement under Medicare Part A, but that course of action would have required compliance with regulatory requirements that petitioner regarded as bur-

4. The United States filed suit against petitioner under the FCA, seeking treble damages and civil penalties. After a bench trial, the district court ruled in favor of the government and issued findings of fact and conclusions of law. Pet. App. 56-71. The court held that petitioner had knowingly caused Asher Clinic to present false claims for payment to the Medicare carrier, Blue Shield of California, between 1992 and 1996. *Id.* at 68-69.

The parties had stipulated to the fact that, during the years 1992-1996, Asher Clinic had submitted 8499 Medicare claims totaling $331,078 for physical therapy services, which were paid to the Clinic through checks made payable to M. Judson Mackby, M.D. See Pet. App. 64-65 (956 claims for $31,735 in 1992, 1387 claims for $52,608 in 1993, 2258 claims for $93,695 in 1994, 2326 claims for $96,482 in 1995, and 1572 claims for $56,558 in 1996). In calculating the government's damages under the FCA, however, the district court explained that "the United States is seeking treble damages for only the 1459 claims that Asher Clinic submitted to Medicare between 1992 and July 1996 which exceeded Medicare's annual payment limit per beneficiary for PTIPs,

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densome. The Clinic would have been required to develop an institutional or administrative structure and to provide additional services. Petitioner avoided those burdens by using Dr. Mackby's PIN. In March 1996, however, Medicare administrators wrote to Dr. Mackby at Asher Clinic's address and requested medical records for an audit. Shortly thereafter, petitioner expended considerable resources to have Asher Clinic certified as a Medicare Part A rehabilitation agency. Asher Clinic's application for certification as a rehabilitation agency was dated June 4, 1996; the Clinic was surveyed on July 10, 1996; and Medicare administrators granted certification on September 13, 1996. The Clinic then stopped billing for Medicare services under Part B. Pet. App. 63-64.

totaling $58,151.64. Treble damages are, therefore, awarded in the amount of $174,454.92." Pet. App. 70. In assessing the appropriate civil penalty under the Act, the court explained that "[t]he United States is also seeking the minimum penalty under the FCA of $5,000 for only one claim, submitted by Asher Clinic per beneficiary each year, that exceeded Medicare's annual payment limit for PTIPs, *i.e.*, 111 claims. Accordingly, the United States is awarded penalties in the amount of $550,000." *Ibid.*

5. The court of appeals affirmed in part and remanded in part. Pet. App. 16-33.

a. The court of appeals affirmed the judgment as to liability, agreeing with the district court that petitioner had knowingly caused false Medicare claims to be submitted to the government. Pet. App. 21-28. Petitioner argued that the Medicare claims were not "false" within the meaning of the FCA "because the claims accurately describe physical therapy services that were actually rendered." *Id.* at 23. The court explained that "the fact that physical therapy services were actually rendered does not negate Asher Clinic's false representation that Dr. Mackby performed the services described on the claim forms or that those services were rendered incident to Dr. Mackby's supervision. It is the representation of Dr. Mackby's involvement that is 'false.'" *Ibid.* The court also held that petitioner had caused the false claims to be presented, *id.* at 24-25, and that he had acted with the requisite scienter, *id.* at 25-28.

b. The court of appeals remanded the case to the district court to determine whether the civil penalties and treble damages awarded by the district court, alone or in combination, were so grossly disproportional to the gravity of petitioner's offenses that they violated

the Excessive Fines Clause of the Eighth Amendment. Pet. App. 28-32. The court explained that both the civil-penalty and treble-damages components of the monetary relief authorized by the FCA are intended, at least in part, to serve punitive purposes, and are therefore subject to Excessive Fines analysis. See *id.* at 30-32.

6. On remand, the district court concluded that the judgment previously entered did not violate the Excessive Fines Clause. Pet. App. 37-55. The court noted that petitioner had "caused 8,499 false claims to have been submitted," and that his conduct had resulted in the improper payment of $331,078 in federal Medicare funds. *Id.* at 42-43. Because petitioner's "maximum exposure" under the False Claims Act was "almost $86 million," the court explained, the judgment against him was "but a fraction of what could have been imposed" under the plain terms of the FCA. *Id.* at 43-44. In the court's view, the fact that the judgment awarded was "far below the amounts which could have been imposed supports the conclusion that the judgment is not grossly disproportionate to the gravity of [petitioner's] conduct." *Id.* at 44.

Petitioner contended that his false claims resulted in no harm to the government, on the theory that if Medicare had not paid Asher Clinic, it would have paid to have the same services performed by another provider. Pet. App. 46. The district court rejected that argument, explaining that the proper measure of the government's damages under the FCA was the amount paid in response to the false claims. *Id.* at 47. The court also rejected petitioner's suggestion that his conduct at most amounted to a minor or technical violation of the Act. See *id.* at 50-51. Finding that petitioner's "submission of false claims to the United States is a *serious*

matter," *id.* at 51, and that petitioner had "engaged in a course of deceit which involved the submission of thousands of false claims over the course of four years," *id.* at 52, the court concluded that the full amount of the judgment it had previously imposed was "necessary and appropriate for purposes of deterrence," *ibid.*

7. The court of appeals affirmed. Pet. App. 1-15. The court noted that, under this Court's decision in *United States* v. *Bajakajian*, 524 U.S. 321 (1998), a "punitive forfeiture violates the Excessive Fines Clause if it is grossly disproportional to the gravity of a defendant's offense." Pet. App. 6 (quoting *Bajakajian*, 524 U.S. at 334). Applying that standard, the court held that the monetary award in this case did not violate the Excessive Fines Clause. *Id.* at 8-14.

The court of appeals explained that petitioner had "used a false Medicare PIN number to procure Medicare payments for which he was not eligible," and that each of the 8499 Medicare claims that petitioner had submitted using Dr. Mackby's PIN number constituted a distinct violation of the FCA. Pet. App. 8. "[A]lthough the government sought damages only for the claims that exceeded the PTIP cap, [petitioner] did not actually qualify as a PTIP after the departure of Leary in 1988 and thus was not eligible to receive any Medicare funds, let alone funds that exceeded the cap." *Id.* at 8-9. The court also found that, unlike the defendant in *Bajakajian*, petitioner was "among the class of persons targeted by the" statute under which penalties were imposed, because the FCA "targets those who knowingly make a false claim for payment to the government." *Id.* at 9.

In determining whether the monetary relief awarded by the district court was grossly disproportional to the seriousness of petitioner's offenses, the court of appeals

found it appropriate to consider the maximum penalty provided for by Congress, which the court deemed "instructive but not dispositive of the constitutional question." Pet. App. 9. The court explained that, if the government had sought treble damages and civil penalties for all 8499 false claims, petitioner could have been subject to a civil penalty of up to $84,990,000 and treble damages of up to $993,234. *Id.* at 10. The court found that "[t]he substantial difference between the actual judgment against [petitioner]—treble damages of $174,454.92 and a civil penalty of $555,000—and the maximum available penalties weighs against a finding of gross disproportionality." *Ibid.* The court also noted that, under the Sentencing Guidelines, petitioner might have been subjected to "a term of imprisonment of 37-46 months, as well as restitution for the full amount of the loss," in a criminal prosecution based on the same conduct. *Id.* at 11. Finally, the court found that some part of the judgment against petitioner was properly viewed as remedial in character. *Id.* at 13. The court of appeals concluded that, "[c]onsidering both [petitioner's] culpability and the harm caused by his offense, * * * the full $729,454.92 judgment against [petitioner] is not grossly disproportional to the gravity of his offense." *Id.* at 13-14.

ARGUMENT

The decision of the court of appeals is correct and does not conflict with any decision of this Court or of another court of appeals. Further review is not warranted.

1. Petitioner contends (Pet. 15-19) that the government failed to prove in this case that the Medicare claims submitted by Asher Clinic were "false" within the meaning of the FCA. Petitioner relies (see Pet. 17-

18) on decisions issued in criminal false claim and false statement prosecutions under 18 U.S.C. 287 and 1001, in which courts of appeals have held that, because the government must prove falsity beyond a reasonable doubt, a defendant cannot be found guilty if his conduct rests on a reasonable interpretation of governing law. Petitioner's argument fails for two reasons.

First, the instant case involves a civil FCA action, not a criminal prosecution. The fact that the civil monetary remedies available under the Act may serve in part to punish the offender, see *Cook County* v. *United States ex rel. Chandler*, 538 U.S. 119, 129-130 (2003), does not mean that all of the rules governing criminal prosecutions—including the requirement of proof beyond a reasonable doubt—are applicable to FCA civil suits. Petitioner's reliance (Pet. 15) on *Hays* v. *Hoffman*, 325 F.3d 982 (8th Cir.), cert. denied, 124 S. Ct. 277 (2003), is misplaced. Although the Eighth Circuit in *Hays* held that the district court had attributed to the defendant an unduly large *number* of false claims, see *id.* at 992-994, the court did not announce any overarching principle that civil suits under the Act must conform to the rules governing criminal prosecutions.[6]

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[6] In *United States* v. *Bornstein*, 423 U.S. 303 (1976), this Court stated that, in construing the FCA provisions governing civil liability, it was "actually construing the provisions of a criminal statute." *Id.* at 313 n.8 (quoting *United States* v. *McNinch*, 356 U.S. 595, 598 (1958)). That statement was correct in 1976, but it is no longer an accurate characterization of the relationship between the applicable civil and criminal false claims provisions. As the Court explained in *Bornstein*, the civil provisions of the False Claims Act in effect at that time relied on a repealed criminal provision for specification of the acts giving rise to civil liability. 423 U.S. at 307 n.1. The current civil provisions of the False Claims Act, however, are entirely self-contained, see 31 U.S.C. 3729 *et seq.*, and are

In any event, petitioner is wrong in suggesting (see Pet. 16-17) that the falsity of Asher Clinic's Medicare claims turned on the interpretation of ambiguous regulatory provisions. The courts below found those claims to be "false," not because they rested on a misinterpretation of arcane Medicare regulations (see Pet. 16), but because the claim forms represented that the relevant physical therapy services had been performed by Dr. Mackby or under his direction, when in fact Dr. Mackby had no involvement in the provision of those services. See, *e.g.*, Pet. App. 23 (court of appeals states that "[i]t is the representation of Dr. Mackby's involvement that is 'false,' and that falsity is sufficient to satisfy the first element of an FCA claim"); *id.* at 67-68 (district court finds that "[t]he 'lie' on the [claim] forms * * * is Dr. Mackby's PIN," which "indicated to Medicare that the physical therapy provided [was] performed by Dr. Mackby or 'incident to' his services"). The district court considered petitioner's asserted justifications for using Dr. Mackby's PIN on the Medicare claim forms and found that those justifications lacked credibility. See *id.* at 60-63. The Medicare claims that petitioner caused to be submitted were therefore "false" because they misrepresented facts bearing on the Clinic's entitlement to payment, not because they reflected a misunderstanding of applicable law.

Petitioner further contends (Pet. 17) that Asher Clinic could reasonably have interpreted the applicable Medicare requirements as permitting it to be paid for its services as a "supplier" of independent physical therapists. The court of appeals found that petitioner "did not actually qualify as a PTIP after the departure

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codified separately from the criminal prohibition contained in 18 U.S.C. 287.

of Leary in 1988 and thus was not eligible to receive any Medicare funds." Pet. App. 9. In any event, Asher Clinic did not seek Medicare payments as a PTIP during the time period relevant here; rather, it billed as a provider of physical therapy provided by or under the supervision of Dr. Mackby. See pp. 4-5, *supra*.

2. Petitioner contends (Pet. 20-23), that the government suffered no damages as a result of the false claims submitted by Asher Clinic because (a) the Clinic in fact provided the physical therapy services for which Medicare payments were made, and (b) the relevant patients would likely have obtained equivalent services from other providers at federal expense if Asher Clinic had been found to be ineligible for Medicare reimbursement. Those claims lack merit.

The False Claims Act imposes liability on any person who "knowingly presents, or causes to be presented, * * * a false or fraudulent claim for payment or approval," 31 U.S.C. 3729(a)(1), or who "knowingly makes, uses, or causes to be made or used, a false record or statement to get a false or fraudulent claim paid or approved by the Government," 31 U.S.C. 3729(a)(2). The Act thus focuses on the defendant's improper attempts to obtain money from the public fisc; and, under established principles, the appropriate measure of damages under the FCA is "the amount that [the government] paid out by reason of the false statements over and above what it would have paid if the claims had been truthful." *United States* v. *Woodbury*, 359 F.2d 370, 379 (9th Cir. 1966). Here, if Asher Clinic had truthfully informed the government that Dr. Mackby was neither providing nor supervising the provision of the physical therapy services performed at the Clinic, the Clinic would have received *no Medicare funds at all* (because it was ineligible to

receive such funds as a PTIP). See p. 4, *supra*. The fact that the government might have *lawfully* reimbursed qualified suppliers for providing physical therapy to some of the same patients does not alter that reality.

Petitioner's challenge to the district court's computation of damages in this case is particularly misguided in light of the discretion shown by the government in its assertion of damages claims. During the period from 1992-1996, Asher Clinic submitted 8499 Medicare claims, for which it received a total of $331,078, see p. 6, *supra*, even though the Clinic was ineligible to receive *any* Medicare reimbursement during the years in question. See Pet. App. 8-9. The United States sought damages, however, "for only the 1459 claims that Asher Clinic submitted to Medicare between 1992 and July 1996 which exceeded Medicare's annual payment limit per beneficiary for PTIPs." *Id.* at 70; see *id.* at 8-9. (Those claims totaled $58,151.64, and the district court awarded treble damages in the amount of $174,454.92. *Id.* at 70.) The government thus sought damages only for those Medicare claims as to which the participation of a physician in rendering the underlying services was a legal prerequisite to payment. Since it is undisputed that the Clinic's services were not performed by or under the direction of a physician, there is no basis for petitioner's contention (Pet. 21) that the government received in substance the services for which it paid.

Petitioner also contends (Pet. 21) that, if the Medicare carrier had been aware that Asher Clinic's services were performed by physical therapists rather than by doctors, and if it had therefore denied reimbursement in excess of the annual PTIP cap, its action "would likely have caused the patients to go elsewhere to receive their services, causing Medicare to have paid

the same amounts it paid Asher Clinic." Petitioner cites no case, however, in which a court has relied on speculation of that character as a basis for denying the government's claim for damages for payments wrongfully obtained by the recipient. Absent any conflict in authority, petitioner's statutory challenge to the damage calculation in this case does not warrant further review.[7]

3. Petitioner contends (Pet. 24-26) that the circuits are divided on the question whether False Claims Act liability can exist without proof of damages by the government. Even if that question otherwise warranted this Court's review, it is not presented in this case, since both of the courts below held that the government

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[7] The criminal cases on which petitioner relies (see Pet. 23) involved either the loss calculations used in applying the Sentencing Guidelines, or the determination whether restitution is owed, rather than the issue of damages in a civil False Claims Act case. Petitioner's reliance (see Pet. 21-22) on *United States* v. *Cooperative Grain & Supply Co.*, 476 F.2d 47 (8th Cir. 1973), and *Ab-Tech Construction, Inc.* v. *United States*, 31 Fed. Cl. 429 (1994), aff'd, 57 F.3d 1084 (Fed. Cir. 1995), is also misplaced. The decision in *Cooperative Grain* predates the comprehensive changes Congress made to the False Claims Act in 1986. In any event, because the misrepresentation that Dr. Mackby was responsible for the relevant services caused the government to pay money to which Asher Clinic was not entitled, petitioner's proposed rule that "the government should only be allowed to recover damages that it has actually suffered as a result of a claim being submitted" (Pet. 21) would provide no basis for reducing or setting aside the damage award in this case. The court in *Ab-Tech Construction* held that the government was not entitled to damages because it "got essentially what it paid for." 31 Fed. Cl. at 434. Here, by contrast, the government paid for services performed by a physician or under his supervision, when in fact Dr. Mackby had no role in the provision of the services for which the Clinic sought and received Medicare funds.

had proved damages. In any event, the text of the FCA makes clear that a defendant may be held liable under the Act without proof of actual harm to the government, and no court of appeals has adopted a contrary rule.

The FCA provides that any person who "knowingly *presents, or causes to be presented*" a false claim to the government "is liable to the United States Government for a civil penalty of not less than $5,000 and not more than $10,000, plus 3 times the amount of damages which the Government sustains." 31 U.S.C. 3729(a) (emphasis added). By its terms, the FCA forbids the *presentment* of a false claim, without regard to whether the claimant succeeds in obtaining government funds, and the Act establishes civil penalties and treble damages as separate elements of relief. When a false claim for payment is "knowingly * * * presented," the plain terms of the Act make the claimant liable for civil penalties, even if the government suffers no resulting harm (as, for example, when the federal officials to whom the claim is submitted recognize its falsity and therefore decline to pay it).

Contrary to petitioner's suggestion, no circuit conflict exists on this question. The cases on which petitioner relies simply recognize that the FCA does not broadly prohibit all false *statements* made to the government; rather, the Act applies only to those misrepresentations having a potential effect on the disbursement of federal funds. See, *e.g.*, *Mikes* v. *Straus*, 274 F.3d 687, 696 (2d Cir. 2001) (FCA addresses misrepresentations that are "aimed at extracting money the government otherwise would not have paid"); *ibid.* (statute "reaches only those claims with the potential wrongfully to cause the government to disburse money"); *id.* at 697 (no liability when false statement "would not have influenced the

government's decision to pay"). That requirement of a *potential* fiscal impact—a requirement that is implicit in the Act's focus on the presentation of "claim[s] for payment or approval," 31 U.S.C. 3729(a)(1)—does not mean that the government must prove that it *actually* disbursed funds or suffered pecuniary harm as a result of the defendant's conduct. The cases on which petitioner relies are consistent with the foregoing analysis —as petitioner himself ultimately acknowledges. See Pet. 25 (characterizing various court of appeals decisions as "holding that some damage *or at least some potential effect on the treasury* is a required element of an FCA cause of action") (emphasis added).

4. Petitioner contends (Pet. 26-29) that the imposition of $555,000 in civil penalties in this case violated the Excessive Fines Clause. That argument ignores the discretion exercised by the government in seeking penalties substantially less than those statutorily-authorized for the full scope of petitioner's misconduct. The court of appeals correctly rejected petitioner's Excessive Fines Clause challenge to the penalty award (Pet. App. 8-14), and that constitutional claim does not warrant further review.

This Court has held that "a punitive forfeiture violates the Excessive Fines Clause if it is grossly disproportional to the gravity of a defendant's offense." *Bajakajian*, 524 U.S. at 334. The court of appeals properly relied on several factors in affirming the district court's award of monetary relief in this case. The court explained that petitioner had "submitted 8499 claims using Dr. Mackby's PIN" and that each of those claims constituted a distinct violation of the FCA. Pet. App. 8. It noted that, if petitioner had been subjected to the maximum civil sanctions available under the FCA, he could have been ordered to pay $84,990,000 in

civil penalties and treble damages of $993,234. *Id.* at 10. The court of appeals observed as well that petitioner's conduct could also have formed the basis for criminal prosecution, with a potential Guidelines sentencing range of 37-46 months of imprisonment. *Id.* at 11. Finally, the court concluded that some portion of the judgment was remedial rather than punitive. *Id.* at 13. Those facts amply justify the court of appeals' conclusion that the monetary award in this case was not "grossly disproportional" to the gravity of petitioner's offense.

Although the district court found that petitioner had caused 8499 separate false claims to be submitted, thereby obtaining $331,078 in Medicare funds to which it was not entitled, see Pet. App. 42-43, 45, the government sought civil penalties "for only 111 claims, reflecting one claim per beneficiary per year that exceeded the PTIP payment limit," *id.* at 43.[8] Petitioner contends (Pet. 27) that the court of appeals, by deciding the Excessive Fines Clause issue on the premise that petitioner had actually submitted 8499 false claims to the government, has improperly condoned a civil penalty that is *lower* than the per-claim minimum authorized by the FCA. That argument lacks merit. The courts below did not purport to impose *liability* for 8499 false claims; they simply recognized that the full extent of petitioner's misrepresentations should be considered in determining whether the monetary relief in this case was "grossly disproportional" to the gravity

[8] The government's request for civil penalties was thus even more limited than its request for treble damages. The government sought and received treble damages for each of the 1459 claims "that exceeded Medicare's annual payment limit per beneficiary for PTIPs." Pet. App. 4-5.

of petitioner's misconduct. Petitioner cites no decision suggesting that a court, in considering an Excessive Fines Clause challenge to a civil monetary sanction, must effectively disregard the government's discretionary judgment to limit the fines it seeks and is foreclosed from taking into account wrongful conduct by the defendant that is closely related to the offense(s) for which the sanction is imposed. Cf. *United States* v. *Watts*, 519 U.S. 148, 151-157 (1997) (per curiam) (sentencing court in criminal case may rely on evidence indicating that defendant committed additional criminal acts).

Petitioner contends (Pet. 28) that "the FCA will always produce an unconstitutional result in a case, such as [petitioner's], involving hundreds or thousands of relatively small claims, because the penalties required by the statute are always disproportional to any possible harm or loss the government could suffer." That sweeping assertion is substantially overbroad, particularly in light of the fact that the government may incur significant costs of detection and investigation, see *Chandler*, 538 U.S. at 130-131, even when the dollar amounts of individual false claims are relatively small. But even assuming, *arguendo*, that a civil penalty of $5000-$10,000 for each of the 8499 false claims that petitioner caused to be submitted (*i.e.*, $42,495,000-$84,990,000) would have been constitutionally excessive, it does not follow that the government is foreclosed from collecting any civil penalty at all. To the contrary, the government's exercise of discretion in seeking recovery only for a subset of the most problematic claims avoids any potential Excessive Fines difficulties, yet can still yield a meaningful civil penalty consistent with the defendant's misconduct. Consistent with the government's litigating position, the district

court awarded civil penalties for a small percentage of petitioner's false claims, while recognizing that evidence of larger-scale misconduct (and the resulting substantial statutorily-authorized potential fines) was relevant to the question whether the penalties imposed were "grossly disproportional" to the gravity of petitioner's wrongdoing. Neither the FCA nor the Eighth Amendment precludes that approach.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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